

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027013

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3830

FILED AUG 2 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in lb. 50 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Ralph Clinic, 529 High land		d. STREET ADDRESS (If outside, give location) 1708 East 39th St.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last JOHN DAVID CLOUGH			4. DATE OF DEATH Month Day Year July 22 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-15-89	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerical Work			11. BIRTHPLACE (City and state or country) Winfield, Kansas		
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME James Fowler Clough		13b. MOTHER'S MAIDEN NAME Isabel Wilson		14. NAME OF HUSBAND OR WIFE Myrtle E. Clough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			17. INFORMANT Address John Clough, Jr. Reseda, California		

18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial PNEUMONIA. DUE TO (b) Malnutrition DUE TO (c) GENERAL DEBILITY		INTERVAL BETWEEN ONSET AND DEATH 48 hrs Several weeks Several months
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		

21. I attended the deceased from July 19, 1962 to July 21st, 1962 and last saw him alive on July 21, 1962	
Death occurred at 12:45 A. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Ralph Emerson Duncan	22b. ADDRESS 529 Highland Ave. K.C. Mo.	22c. DATE SIGNED 7/23/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 24, 62	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		

24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kan. City, Mo.	25. DATE RECD. BY LOCAL REG. 7-24-62	26. REGISTRAR'S SIGNATURE Ruth N Long
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Ralph Emerson Duncan

Medical Certification

[illegible]**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

d. Norman W. Tolson

Licensed Embalmer No. 4889

P. O. Address

Palmer No. 4889
Lathrop, W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above: